



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS ALLIANCE MEDICAL GROUP

Respondent Name

CASTLEPOINT NATIONAL INSURANCE

MFDR Tracking Number

M4-16-0294-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

October 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Initially, when patient was brought in to our facility we contacted carrier to verify what was compensable we were told at the time that cervical, lumbar, bilateral wrist, rt ankle and ribs were accepted. Date of service listed above were denied as non compensable...I have placed several calls to adjuster Maria Tovar to request a PLN to determine what is accepted I left numerous messages she never responded I also spoke to Patty L. which is a rep that refused to send me a PLN in writing... All documentation has been provided for accurate review. Services have been provided to the patient to further help resume his duties for employment, we feel we have taken the necessary steps to help him through the process... Therefore, we request that this be reconsidered for prompt payment."

Amount in Dispute: \$2,775.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached hereto as Exhibit A, and incorporated herein for all purposes, is the following information regarding this dispute: 1. Medical Dispute Resolution Request/Review ('DWC-60'); 2. EOBs; 3. PLN-a dated 3/11/14; and 4. CCH Decision and Order dated June 26 [sic], 2014.

Response Submitted by: Downs ♦ Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2014 through April 17, 2014	Physical Therapy Services Office Visit Work Status Report	\$2,775.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedures for resolving disputes
3. The services in dispute were reduced/denied by the respondent with the following reason code:

- 1 – (214) – Workers' Compensation claim adjudicates as non-compensable. This Payer not liable for claim or service/treatment.

Issues

1. Has the compensability of injury issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Labor Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." The services in dispute were denied due to an unresolved compensability of injury issue. The disputed issue involved whether the injured worker sustained a compensable on the job injury on February 20, 2014. A benefit review officer with the Division held a benefit review conference on April 22, 2014 to mediate resolution of the disputed issues. The parties were unable to reach an agreement. A Contested Case Hearing was held on June 13, 2014 to resolve the disputed issue. A Decision was issued on June 23, 2014 that found that the claimant did not sustain a compensable on the job injury on February 20, 2014. The division concludes that the compensability of the injury issue is resolved.
2. The treatments in dispute were rendered for an injury which was found not compensable according to the Contesting Case Hearing as discussed above. The requestor rendered health care to this injured employee for the non-compensable injury; therefore, no reimbursement can be recommended for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	November 5, 2015 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.